

RESTON PODIATRY ASSOCIATES, LTD.

Patient's FIRST _____ M.I. _____ LAST _____ SEX: _____

Home Address _____ City _____

State _____ Zip _____ Home Phone: _____ Cell Phone: _____

E-MAIL : _____ SSN: _____ - _____ - _____ AGE: _____ DOB: ____/____/____

Marital Status: (S M D W SEP) Patient's occupation _____

Employer _____ Address _____

City/State/Zip _____

Work Phone () _____ Spouse's Employer _____

Spouse's Name _____ Spouse's DOB: ____/____/____

Spouse's Work Phone () _____

Name of Financially Responsible Person _____

Patient Spouse Parent Other Responsible Person's DOB: ____/____/____ SSN: ____-____-____

Address (If different from patient) _____

Parent's name (If patient is minor) _____

Parent's Employer _____ Parent's Occupation _____

Mother's Work Phone _____ Father's Work Phone _____

Name of nearest relative not living with you _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____

Referred to Our Office By: _____

Address _____ City/State/Zip _____

MEDICAL INSURANCE INFORMATION

Do you have Medicare? Yes or No Medicare ID # _____.

OTHER INSURANCE

Insurance Company Name _____ Address _____

City/State/Zip _____ I.D. No. _____

Group No. _____ Subscriber Name _____

Subscriber's Social Security No. _____ Subscriber Birthdate _____

WE INVITE YOU TO DISCUSS ANY QUESTIONS REGARDING OUR SERVICES OR OUR FEES.

PLEASE TURN TO THE BACK OF THIS PAGE AND ANSWER ALL QUESTIONS.

THANK YOU.

CHIEF CONCERN/PRESENT ILLNESS:

What is your present foot problem _____

How long have you been bothered by the above _____

What have you done for your foot problem _____

Was your foot problem a result of an accident _____ If so, date of accident _____

Circumstances of accident _____

MEDICAL HISTORY:

Family Doctor's Name _____ Address _____ Phone () _____

Are you now or have you been under a physician's care during the past 2 years: yes _____ no _____

Date of Last Physical exam _____ Are you presently taking any medication Yes ___ No _____

If yes, name of medication: _____

Have you ever tested **positive** for Human Immunodeficiency Virus (HIV) Yes _____ No _____

Do you have a history of Alcoholism or Drug Dependency? Yes _____ No _____

Are you Pregnant? Yes _____ No _____ Do you smoke ? Yes _____ No _____

Check if you have been treated for:

High blood Pressure _____ Diabetes _____ Cancer _____ Arthritis _____ Broken Bones _____

Nervous Condition _____ Glaucoma _____ Ulcers _____ Anemia _____ Heart disease _____

Kidney Disease _____ Hepatitis _____ Gout _____ Epilepsy _____ Bleeding tend. _____

Liver Trouble _____ Asthma _____ TB _____ Allergies _____ DVT _____

Blood Clot _____ Other _____

Have you ever experienced any unusual or allergic reactions to **LATEX** or **Any Medications** (such as)

Novocain, Penicillin; etc: **If yes**, which one (s) _____

Have you had surgery?:

Type: _____ year _____

FAMILY HISTORY: Have any of your blood relatives had:

Arthritis _____ Cancer _____ Heart Disease _____ High Blood pressure _____ Kidney Disease _____

Obesity _____ Foot problems similar to yours _____ Diabetes _____

Is there any other general or foot health information that should be known? _____

- Virginia Law requires us to inform you that your blood may be tested for the HIV (AIDS) virus if any health care worker is accidentally exposed to your blood in a manner that could transmit HIV infection. Your consent is **NOT** needed, but you **will be** informed if tested.

- ***I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.***

PATIENT SIGNATURE X _____ DATE _____ Revised 5-25-07

PATIENT NAME _____

PATIENT ACCOUNT # _____

PATIENT IS: PLEASE CIRCLE ONE:

Employed Unemployed Full time student Part time student

PATIENTS RELATIONSHIP TO INSURED: PLEASE CIRCLE ONE:

Patient Spouse Child Other: _____

PRIMARY INSURANCE:

SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S SS# _____

SUBSCRIBER'S EMPLOYER _____

ADDRESS OF EMPLOYER _____

PHONE NUMBER: __ () _____

SECONDARY INSURANCE:

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S SS# _____

SUBSCRIBER'S EMPLOYER _____

ADDRESS OF EMPLOYER _____

PHONE NUMBER: __ () _____

ALL INSURANCE COVERAGE MUST BE DISCLOSED. FAILURE TO DO SO CONSTITUTES

FRAUD...

PATIENT AUTHORIZATION

I hereby authorize **RESTON PODIATRY ASSOCIATES LTD** to release medical information acquired in any examination or treatment, according to the following:

(ASSIGNMENT OF BENEFITS)

I request that payment of authorized insurance benefits be made to **RESTON PODIATRY ASSOCIATES LTD**, for services furnished to me by the physician.

(MEDICARE PATIENTS:)

This office accepts Medicare assignment. Medicare patients are fully responsible, for the initial yearly deductible and the 20% co-payment. Federal law requires that physicians collect this amount. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service

I also understand that I (husband, wife, dependent) am fully responsible for my charges, and filing of claims on my behalf by **RESTON PODIATRY ASSOCIATES LTD** is done, **PURELY AS A COURTESY.**

I understand that a \$35.00 fee will be added to my account for any unpaid balance that is sent to **EQUIFAX CREDIT INFORMATION SERVICES**

PLEASE NOTE: A \$25.00 WILL BE CHARGED FOR ALL RETURNED CHECKS . INTEREST WILL BE CHARGED AT 18% ON ANY BALANCE NOT PAID WITHIN 30 DAYS.

PATIENT SIGNATURE _____

DATE _____

WE WILL WAIT UNTIL WE HEAR FROM YOUR INSURANCE COMPANY, THEN IT WILL BE YOUR RESPONSIBILITY TO CLEAR YOUR ACCOUNT IN FULL.

ALL COPAYS AND CASH ITEMS ARE PAYABLE ON THE DATE OF SERVICE

THANK YOU

WORKMAN'S COMPENSATION/COMPENSATION CLAIMS

I understand that this claim is being submitted as a compensation claim for an injury. If compensation is denied, I understand that I will be fully responsible for all charges.

PATIENT SIGNATURE _____

DATE _____